Washington State Health Care Authority

REFERENCE / AUTH NUMBER
TODAY'S DATE

LONG TERM ACUTE CARE (LTAC)

Long Term Acute Care Authorization/Update Request

Attn: LTAC Program Manager
(360) 725-5144
Fax: 360-725-1966

☐ Proposed Admit ☐ Admission Info ☐ Extension Request ☐ Readmission ☐ Notice of Discharge

Please attach clinical documentation necessary to determine medical necessity. At discharge, forward discharge summary.

☐ Kindred ☐ Northern Idaho ☐ Regional ☐ Vibra	TELEPHONE NUMBER	FAX NUMBER

CLIENT NAME	PROVIDERONE ID	BIRTH DATE	MEDICARE EXHAUST DATE

DATE ADMITTED TO LTAC	LENGTH OF STAY REQUESTED FROM TO	ESTIMATED TOTAL LOS	LTAC CASE MANAGER

Anticipated discharge plan: ☐ Home ☐ SNF ☐ AFH ☐ Hospital ☐ Other:

LTAC-related diagnoses		
	ICD 9 Dx:	DESCRIPTION:
	ICD 9 Dx:	DESCRIPTION:
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	ICD 9 Dx:	DESCRIPTION:

IDENTIFY THE QUALIFYING CONDITIONS BASED ON WAC CRITERIA (WAC 182.550.2570)

LEVEL I SERVICES:

Client requires eight (8) or more hours of direct skilled nursing care per day AND the client's medical needs cannot be met at a lower level of care due to clinical complexity. LEVEL 1 SERVICES INCLUDE ONE OF THE FOLLOWING:

☐ Ventilator weaning care

☐ Care for a client who has:

- Wounds that require on-site wound care specialty service and daily assessment and/or interventions; AND
- At least one comorbid condition (such as chronic renal failure requiring hemodialysis).

LEVEL II SERVICES:

Client requires four (4) or more hours of direct skilled nursing care per day AND the client's medical needs cannot be met at a lower level of care due to clinical complexity. LEVEL 2 SERVICES INCLUDE ONE OF THE FOLLOWING:

☐ Ventilator care for a client who is ventilator dependent and is not weanable AND has complex medical needs; OR

☐ Care for a client who:

- Has a tracheostomy;
- Requires frequent respiratory therapy services for complex airway management AND has the potential for decannulation; AND
- Has at least one comorbid condition (such as quadriplegia).

OTHER:

☐ **Client does not meet above WAC criteria. Provide clinical information to justify medical necessity of LTAC-level care.**

Ventilator patients	Discharge/Transfer Information
Currently on Vent: ☐ Yes ☐ No Last Day on Vent: Decannulated: ☐ Yes, date: ☐ No	Discharge Date: Disposition: **FAX THE DISCHARGE SUMMARY TO LTAC Program Manager**

Did you contact Home and Community Services (HCS) for assistance discharging this patient?

Name of DSHS Case Manager (Social Worker or Nurse), if known:

Is/was patient difficult-to-place? ☐ No ☐ Bariatric ☐ Behavioral ☐ High respiratory needs

☐ High medical needs ☐ Other, explain